RHODE ISLAND DEPARTMENT OF HEALTH
Health Plan Application Guidelines

The Rhode Island Department of Health (Department) provides the *Health Plan Application Guidelines* as an outline for the Health Plan application process, but these Guidelines do not replace nor supersede Rhode Island General Laws 23-17.13, 23-17.12, nor their accompanying Rules and Regulations, R23-17.13-CHP (HP) and R23-17.12-UR (UR).

REQUIRED ELEMENTS FOR A COMPLETE HEALTH PLAN APPLICATION	
Health Plans with total Rhode Island Enrollment of Less than 5,000	**Application & Assurances Forms Only (I.)**
Health Plans with total Rhode Island Enrollment Between 5,001 & 10,000 & RIte Care and Medicare Health Plans	**All of the Following Requirements *Except* Disclosure of Information (I., III., IV., and V.)**
Health Plans with total Rhode Island Enrollment of More than 10,000	**All of the Following Requirements (I., II., III., IV., and V.)**

ALL APPLICATIONS MUST INCLUDE A "TABLE OF CONTENTS" AND BE FORMATTED ACCORDING TO THE FOLLOWING OUTLINE TO BE CONSIDERED FOR CERTIFICATION/RECERTIFICATION:

I. APPLICATION INFORMATION

TAB A:

- *Application for Health Plan Certification / Re-certification* for each health plan for which you are applying for certification (completed, signed, dated, and stamped or sealed by Notary Public)
- *Assurances* forms (completed, signed, dated, and stamped or sealed by Notary Public)
- Ownership listing & description (as described on *Application for Health Plan Certification / Re-certification* form)
- Description of Health Plan (as described on *Application for Health Plan Certification / Re-certification* form)

II. DISCLOSURE OF INFORMATION

TAB B:

- **Provide a written plan, including timeframes, for the distribution of the *Consumer's Guide to Health Plans in Rhode Island* and the *Consumer's Right to Know About Health Plans in Rhode Island* disclosure documents. (HP 4.1)**

- **Provide notification of the health plan's website address for public access to information.**

- **Provide paper copies of all informational/disclosure materials for <u>each</u> health plan for which are applying for certification.**

- **Follow the *Instructions for Submitting Consumer Disclosure Documents* for submission to and approval from the Department.**

  - Health Plans must follow the standardized format, *Consumer's Right to Know About Health Plans in Rhode Island,* available on the Department's website, www.health.ri.gov/hsr/managed/man_care.htm

III. POLICIES & PROCEDURES

- **Provide comprehensive written policies and/or procedures that address the following issues, for the health plan for which you are applying for certification.**

TAB C: Roles and Responsibilities

- A health plan must have a mechanism to measure enrollee satisfaction and maintain satisfaction measures {HP 4.3 (t)}
- A health plan must maintain oversight & accountability for all delegated activity through a formal agreement describing the delegated function(s) and oversight program {HP 2.6}
- Medical Director responsible for: {HP 3.4}
  - the provision, management, & direction of health care services
  - defining responsibilities & inter-relationships of professional services
  - the coordination, supervision, & functioning of professional services
  - the achievement & maintenance of the quality management of professional practices through peer review mechanisms
  - reviewing of each quality of care complaint {HP 6.9}

TAB D: Availability & Accessibility of Services {HP 6.0}

- availability & accessibility standards in all geographic areas where the health plan has enrollees
- timeframes for preventive services, including routine primary care appointments, specific to age and gender
- a mechanism that provides enrollees timely access to information
- an emergency services policy that outlines:
  - how emergency services are available and accessed immediately
  - protocol when treating provider requests authorization for post-stabilization treatment
- payment of examinations to determine if emergency services are necessary

- urgent services available within 24 hours of request -- includes physician, or designee,

availability by telephone 24 hours/day, 7 days/week
- distribution of emergency services policy to each enrollee at initial enrollment
  - circumstances under which enrollee may seek attention prior to contacting the health plan
  - criteria for accessing emergency services
- distribution of a participating provider list to enrollees/subscribers at least annually, whenever revised/updated, and upon request with names & office locations listed by care specialty
- published phone number(s) so a subscriber/enrollee can:
  - confirm the status of any provider
  - receive administrative or appeal process information
  - file a complaint
  - receive timely access to information

TAB E: Continuity of Care {HP 6.3}

- coverage of necessary health care services 24 hours/day, 7 days/week
- in the event of contractual changes with participating providers, enrollees may transfer care to alternate participating provider in same/similar specialty
  - mechanism to transfer must be in accordance with HP 5.14.2 (a)

TAB F: Quality Management Program {HP 6.4}

- includes standards, criteria, and procedures for ongoing assessment of the quality of health care services provided and the appropriateness of health care resources used
- monitors quality of patient outcomes including specifically: primary care services; high-volume specialty services; substance abuse services; mental health services; and preventive health services
- data collection, based on samples of enrolled population, to measure performance and patient results; make recommendations to providers; adopt changes based on data; and track/document quality of clinical care
- routine reporting of results of quality management program to governing body, administration, providers, and the Department
- identify, evaluate, and resolve potential/actual quality problems with evidence of follow-up
- remedial action plan for correction of deficiencies regarding individual providers, organizational performance, or whenever inappropriate or substandard services have been provided or needed services failed to be provided
- evaluation mechanism to measure effectiveness of resolution/correction process
- reviews of medical/health records to evaluate continuity, coordination, and quality of patient care in general, and on the basis of specific diagnosis and/or procedures
- multi-disciplinary committee to oversee the quality management program, reporting to governing body and medical director

TAB G: Complaints (defined in HP 1.3) {HP 6.4 , 6.9}

- identify, evaluate, investigate/follow-up, resolve and track/document potential and actual problems in a timely manner
- identify who in the health plan is responsible for processing and follow-up of complaints
- plan to resolve identified problems with evidence of follow-up on recommendations
- compliance with UR
- quality of care complaints forwarded to the health plan's medical director or his/her designee
- quality of care complaints are reviewed by the quality assurance committee
- documentation of findings of review of any quality issue and any resultant remedial action
- inform complainant of review findings within 60 business days of receipt of necessary

information except for those decisions in accordance with UR
- notify complainants they have right to notify Department if not satisfied with outcome of the health plan's internal complaint/appeal processes

TAB H: Confidentiality {HP 6.5}
- mechanism to ensure confidentiality of health care record information in the possession/control of the plan, its employees, its agents, and external parties with whom any contractual agreements exist
- mechanism that allows enrollees to access their own health care information and/or to petition to correct their own medical record/file

TAB I: Professional Provider Application & Credentialing
- the health plan shall take action concerning a professional provider's application within 180 days of receipt of application {HP 5.10}
- each application reviewed by the health plan's credentialing body {HP 5.7}
- if denying an application, provider receives written notification with all reasons for denial within 60 days of receipt of a completed and verified application {HP 5.11}
- professional provider credentialing criteria that includes the following: {HP 5.7.2}
  - based on input from providers credentialed in the plan
  - available to applicants upon request
  - current valid license/registration/certificate required to operate in RI or any other state
  - history relative to any revocation, suspension, probationary status or other disciplinary action regarding a license/registration/certificate required to operate in RI or other state
  - clinical privileges in good standing at a hospital, as applicable
  - valid DEA/Controlled Substance certificate/registration, as applicable
  - education and training consistent with provision of services
  - evidence of current board certification if provider states s/he is board certified
  - evidence of malpractice/professional liability insurance
  - history of professional liability claims resulting in settlements and/or judgements paid (also see section *V. Other Supporting Documents* herein)
- if economic profiling is used in credentialing, provide a written policy to address the issues outlined in HP 5.7.3 and 5.7.4
- a physician shall have an opportunity to amend or terminate the contract as a result of proposed changes within 60 calendar days of receipt of the notice of change; and any decision to terminate a contract by a physician shall be effective 15 calendar days from the mailing of the termination notice
- when a health plan has reason to suspect there is immediate danger to patient(s) linked to a particular providers conduct, it shall notify the Director of Health immediately and shall take appropriate action to protect its enrollees
- any changes to a physician's contract by a health plan shall include, but not be limited to affects upon utilization review and management activities or payment or coverage policies (These changes shall include an explanation of the contractual changes in non-technical terms and sent by mail.)
- professional providers shall not be required to waive their rights to appeal as a condition of their contract

TAB J: Input into Plan Policies & Procedures {HP 6.7, 6.8}

- formal mechanism that allows participating providers to provide periodic input into written policies/procedures of the health plan including: technology; medications; procedures; utilization review criteria; quality criteria; credentialing criteria; medical/health care management procedures
- formal mechanism that allows subscribers/enrollees to provide periodic input into the health plan's procedures & processes regarding the delivery of health care services

IV. PROFESSIONAL PROVIDER CONTRACT ELEMENTS

TAB K: Current (proposed) copies of all provider and professional provider contracts/agreements that are (will be) used by the health plan

<u>The following due process issues must be specifically addressed in, or added to, all professional provider contracts used by the health plan pursuant to HP section 5.12:</u>

- Professional providers shall be notified in writing of any proposed change in contractual privileges with reasons for the proposed actions [or immediate action per HP 5.12.1 (a) (v)];
- A health plan shall maintain an internal appeals process, for professional providers to appeal proposed actions which has reasonable time limits for the resolution of such internal appeals;
- An appeal, if requested, shall be completed prior to implementation of proposed actions; and
- Entities which are also certified as HMOs in RI must include a statement that no enrollee/subscriber shall be liable to any provider for charges/payment of covered services, except as described in section 27-41-26 of RIGL. {HP 5.2}

V. OTHER SUPPORTING DOCUMENTS

TAB L: List of participating providers in the health plan

TAB M: List of those external to the plan who have access to individually identified health care information and the purposes for which they are given such access {HP 6.5 (b)}

TAB N: Copies of any and all contracts/agreements where applicant Health Plan contracts out, carves out, or delegates health plan services to another organization (Those not considered provider or professional provider contracts/agreements)

TAB O: Copy of current NCQA accreditation

TAB P: Copies of the following licenses/certificates, as applicable: Pharmacy; OACF; Radiology; Laboratory, etc.